CONFIDENTIAL PATIENT DATA

Today's Date:

PATIENT INFORMATION			
PATIENT'S LAST NAME: FIRST: MIDDLE	NICKNAME:	DATE OF BIRTH:	SEX: ❑M ❑F
STREET ADDRESS:	HOME PHONE:	WORK PHONE:	PREFERRED PHONE: ❑HOME ❑WORK ❑CELL
ADDRESS LINE 2:	CELL PHONE: CELL PHONE CARRIER:		SOCIAL SECURITY#:
CITY:	STATE:	ZIP CODE:	EMAIL:

MARITAL STATUS: ❑MINOR ❑SINGLE ❑MARRIED ❑SEPARATED ❑DIVORCED ❑WIDOWED ❑PARTNERED

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS? CHOOSE ONE: ❑EMAI L ❑TEXT MESSAG E ❑PHONE CALL ❑NONE

OCCUPATION:	EMPLOYER:
SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH: SPOUSE'S EMPLOYER:

HAVE YOU HAD CHIROPRACTIC CARE IN THE PAST? ❑YES ❑NO DR. NAME:

CURRENT MEDICATIONS:

1. DRUG NAME: _____ STRENGTH (EX. 10MG)_____ CONDITION: _____
2. DRUG NAME: _____ STRENGTH (EX. 10MG) _____ CONDITION: _____
3. DRUG NAME: _____ STRENGTH (EX. 10MG) _____ CONDITION: _____
4. DRUG NAME: _____ STRENGTH (EX. 10MG) _____ CONDITION: _____

VITAMINS/HERBS/MINERALS _____

HOW DID YOU LEARN ABOUT US/REFERRED BY:	PRIMARY CARE PHYSICIAN:

INSURANCE INFORMATION			
PRIMARY INSURANCE:	INSURED ID:		
INSURED NAME:	GROUP NUMBER:		
PATIENT IS THE ❑SPOUSE ❑CHILD ❑SELF ❑_____ TO THE INSURED.		INS. DATE OF BIRTH:	
INSURED ADDRESS (IF DIFFERENT FROM PATIENT):			
ADDRESS 2:	CITY:	STATE:	ZIP CODE:
DEDUCTIBLE?	COINSURANCE/COPAY?		
SECONDARY INSURANCE:	INSURED ID:		

PAST MEDICAL HISTORY

Any Serious Illnesses: _____

Any Operations/surgeries: _____

Any Xrays/MRI of your spine: _____

Offices of Dr. Lisa Vizzacco

PATIENT RECORD OF DISCLOSURES

The HIPPA privacy rule gives individuals the right to request on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Home/Cell telephone _____

- ❑OK to leave detailed message
- ❑Ok to text message
- ❑Leave message with call back number only

Work telephone _____

- ❑OK to leave detailed message
- ❑leave message with call back #only

Other persons you allow us to disclose your health information:

ATTORNEY _____PHONE _____

INSURANCE CO. _____PHONE_____

NAME_____ PHONE _____

NAME_____ PHONE _____

IF YOU REQUEST ANY RESTRICTIONS PLEASE LIST BELOW:

NAME_____ PHONE _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I request that payment of medical benefits be made to the above-named doctor on my behalf, for any services provided to me. I authorize the holder of medical and other information about me to release to Medicare and any insurance company information needed to determine these benefits payable for related services. I understand that I am financially responsible for all charges not paid by my insurance company.

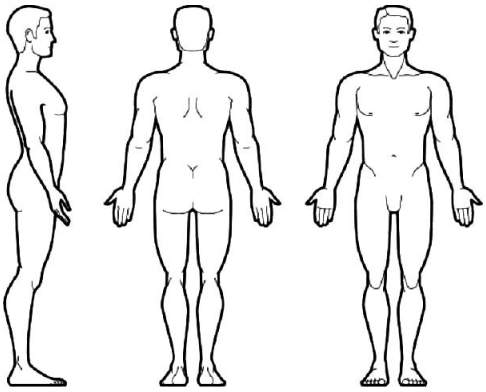
I have received the Notice of Privacy Practices and/or I have been provided an opportunity to review it.

Patient's Name (printed) _____ Date _____

Patient's Signature _____

** OFFICE USE ONLY **

Date	To whom info disclosed	authorized	desc of disclosed info	disclosed by	How disclosed



If your symptoms are caused by a car accident or an injury at work, please ask for an injury form.

Please place an "X" on the drawing to indicate where your **PRIMARY** complaint is
If your pain radiates, use an arrow to draw from where it starts to where it stops.

When did it start _____

Pain rating (1-10, with 1 is minimal and 10 being worst imaginable): ___/10

Pain Frequency**:** ❑Constant (all the time) ❑Frequent (most of Time)
❑Intermittent (comes & goes) ❑Occasional

Pain Description: ❑Aching ❑Burning ❑Cramping ❑Deep ❑Diffuse ❑Dull
❑Numbness ❑Radiating ❑Sharp ❑Shooting ❑Stiffness ❑Tight ❑Tingling
other_____

Is your pain getting better, worse or has it stayed the same? (circle one)

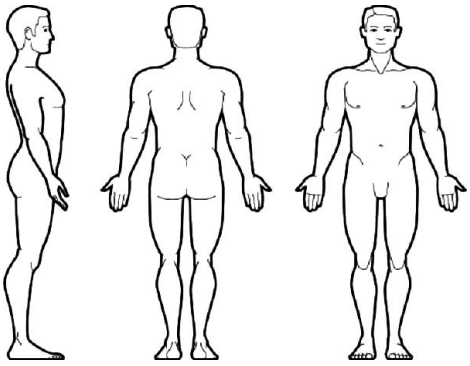
What makes it better? _____

What makes it worse?_____

How did it start/happen? _____

_____

_____



If your symptoms are caused by a car accident or an injury at work, please ask for an injury form.

Please place an "X" on the drawing to indicate where your **Secondary** complaint is
If your pain radiates, use an arrow to draw from where it starts to where it stops.

When did it start _____

Pain rating (1-10, with 1 is minimal and 10 being worst imaginable): ___/10

Pain Frequency**:** ❑Constant (all the time) ❑Frequent (most of Time)
❑Intermittent (comes & goes) ❑Occasional

Pain Description: ❑Aching ❑Burning ❑Cramping ❑Deep ❑Diffuse ❑Dull
❑Numbness ❑Radiating ❑Sharp ❑Shooting ❑Stiffness ❑Tight ❑Tingling
other _____

Is your pain getting better, worse or has it stayed the same? (circle one)

What makes it better? _____

What makes it worse? _____

How did it start/happen? _____

_____

_____

Do you have any other pain or symptoms _____

_____

_____